COPAYMENT CHARGES APPLIED TO INDIVIDUALS COVERED AS MEDICALLY NEEDY UNDER THE PLAN

A. Copayment charges apply to all covered services except those specified in Section 4.18 and the following:

1. Laboratory services.

2. The professional component of diagnostic radiology, nuclear medicine, radiation therapy and medical diagnostic services, when the professional component is billed separately from the technical component.

3. Services furnished or authorized by a health insuring organization (HIO), pursuant to 42 CFR Part 434.

4. Services furnished by a home health agency.

5. Services furnished by a psychiatric partial hospitalization program.

6. Immunizations dispensed by a physician. (Medically needy recipients are eligible for immunizations only when provided under the EPSDT program).

7. Rental of durable medical equipment. (Medically needy recipients are eligible for durable medical equipment only when provided or authorized by a home health agency).

8. Specific ostomy supplies. (Medically needy recipients are eligible for surgical supplies only when provided or authorized by a home health agency.)

9. Specific oxygen services. (Medically needy recipients are eligible for durable medical equipment only when provided or authorized by a home health agency.)

10. Outpatient services when the Medical Assistance fee is under $2.00.

11. Medical examinations when requested by the Department.

* ~~12. Providers' mileage when billed separately from the medical service.~~

13. Screenings provided under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

B. All charges are in the nature of nominal copayments paid by recipients to providers.

C. The amount of the copayment, which is to be paid to providers by recipients and which is deducted from the Commonwealth's Medical Assistance fee to providers for each service is as follows:

* ~~1. For all psychotherapy services provided in an outpatient drug and alcohol clinic or an outpatient psychiatric clinic, the copayment is $.50 per unit of service.~~

2. For inpatient hospital services, provided in a general hospital, rehabilitation hospital or private psychiatric hospital, the copayment is $3.00 per covered day of patient care, to an amount not to exceed $21.00 per admission.

* Disapproved per Carolyn Davis letter of 3-7-85

COPAYMENT CHARGES APPLIED TO INDIVIDUALS COVERED AS MEDICALLY NEEDY UNDER THE PLAN

3. For non-emergency services provided in a hospital emergency room, the copayment ı the hospital support component is double the amount shown in paragraph 4, if an approved ıiver exists from the U. S. Department of Health and Human Services. If an approved waiver ›es not exist, the copayment will follow the schedule shown in paragraph 4.

4. When the total component or only the technical component of the following ervices are billed, the copayment is $1.00: diagnostic radiology, nuclear medicine, ıdiation therapy and medical diagnostic services.

5. For all other services, the amount of the copayment is based on the Medical ;sistance fee for the service, using the following schedule:

(a) If the Medical Assistance fee is $2.00 through $10.00, the copayment is $.50.

(b) If the Medical Assistance fee is $10.01 through $25, the copayment is $1.00.

(c) If the Medical Assistance fee is $25.01 through $50, the copayment is $2.00.

(d) If the Medical Assistance fee is $50.01 or more, the copayment is $3.00.

6. When a recipient is covered by a third party resource and the provider is .gible for an additional payment by Medical Assistance, the copayment required of the :ipient may not exceed the amount of the Medical Assistance payment for the item or vice.

~~D. The Department calculates the amount of copayments paid by a recipient and mburses the recipient for copayments in excess of $90.00 in a 6-month period. this culation is based on invoices paid by the Medical Assistance Program and adjudicated ween January through June and July through December of each year, which verify that the ipient~~ paid the copayment.

* Disapproved per Carolyn Davis letter of 3-7-85.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Pennsylvania

A. The following charges are imposed on the medically needy for services:

Service	Type of Service Deduct.	Coins.	Copay.	Amount and Basis for Determination
9. more than one of a specific series of allergy tests provided in a 24 hour period			none	
10. birth center			none	
11. renal dialysis			none	
The following covered services have a recipient copayment charge				
1. psychotherapy			X	$.50 per 1/2 hour of services
2. inpatient hospital services provided in a general hospital, a rehabilitation hospital or a private psychiatric hospital			X	$3 per covered day of inpatient care to an amount not to exceed $21 per admission
3. the total component or only the technical component of the following services (A) Diagnostic radiology (B) Nuclear medicine (C) Radiation therapy (D) Medical diagnostic services			X	$1.00
4. all other covered services			X	Nominal as set forth in 42 CFR 447.54(a)(3) based on the State fee for the service

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Pennsylvania

B. The method used to collect cost sharing charges for medically needy individuals:

/X/ Providers are responsible for collecting the cost sharing charges from individuals.

/ / The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

The provider must accept the recipient's statement that he or she is unable to pay unless the provider has creditable evidence that the recipient is able to pay but refuses.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Pennsylvania

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

Exclusions from cost sharing requirements are programmed into the federally-approved automated claims processing system.

(copy from Attachment 4.18A, p. 3, D)

E. Cumulative maximums on charges:

/ / State policy does not provide for cumulative maximums.

/X/ Cumulative maximums have been established as described below:

The Department calculates the amount of copayments paid by a recipient and reimburses the recipient for copayments in excess of $90.00 in a 6-month period. This calculation is based on invoices paid by the Medical Assistance Program and adjudicated between January through June and July through December of each year, which verify that the recipient paid the copayment.